PUBLIC GOODS POOL
REPORT OF PATIENT SERVICES REVENUE RECEIVED AND SURCHARGE OBLIGATIONS

FREESTANDING CLINICAL LABORATORIES

GENERAL INSTRUCTIONS

Freestanding clinical laboratories issued a permit pursuant to Title V of Article 5 of the Public Health Law (PHL) are required to use the attached forms to calculate their monthly public goods payment liability.

The provisions of PHL Sections 2807-j (1-a)(a)(iii) and 2807-j (3)(c) provide an exemption from the surcharges for freestanding clinical laboratory services provided **on or after October 1, 2000.** Although this exemption has been effectuated, freestanding clinical laboratories must continue to file **monthly** Public Goods Pool reports through December 31, 2001. Thereafter, such laboratories are only required to file the reports for those months during which they receive patient services revenue for affected services rendered during the January 1, 1997 through September 30, 2000, service period.

For reporting periods prior to January 1, 2002, freestanding clinical laboratories are required to file the enclosed Certification Form, Payment Summary and the two most recent service year portions of the Report of Patient Services Revenue Received and Surcharge Obligations each month, even if there is no activity to report. Note however, that for months in the reporting period from January 1, 2001 through December 31, 2001, no 2001 service year report form is required since the surcharges were repealed for freestanding clinical laboratories services provided on or after October 1, 2000. Prior service year portions of the Report of Patient Services Revenue are required to be submitted only when a provider has net patient services revenue and/or prior period adjustments to report which relate to those service years. The report and payment must be submitted (postmarked) to the Pool Administrator on or before the 30th day following the report month (adjusted for weekends and holidays).

Commencing with the January 1, 2002 reporting period, freestanding clinical laboratories must submit the enclosed Certification Form, Payment Summary and those service year portions of the Report of Patient Services Revenue that relate to the revenue received during the month being reported. The report and payment must be submitted (postmarked) to the Pool Administrator 30 days after the close of the month during which the provider received payments relating to the January 1, 1997 through September 30, 2000, service period. Please refer to the current report year's Schedule of Report and Payment Due Dates, which is available on the WEB site, for information concerning the specific forms providers must submit each month.

Upon adjudication of all affected claims, the laboratory must submit a final monthly report (clearly marked "FINAL" in red ink) along with a completed "Change of Designated Provider Status" form (DOH-4117) indicating the effective date when all affected claims were adjudicated. **The Change of Designated Provider Status form and the Public Goods Pool report forms are available on the Department's WEB site at:**

www.health.state.ny.us/nysdoh/hcra/hcrahome.htm

A designated provider's monthly Public Goods Pool reporting obligation does not cease when the provider has had a change of status (i.e., ceased operations, surrendered license, merged with another provider, etc.) The provider's monthly Public Goods Pool reporting obligation, for the service period during which the entity was a designated provider of services under the HCRA, will continue for a period of one year following the end of the year in which the status change occurred or until all claims for such service period have been adjudicated. Once all claims have been adjudicated, the provider must submit a final monthly report (clearly marked "FINAL" in red ink) along with a completed "Change of Designated Provider Status" form (DOH-4117) indicating the effective date when all claims were adjudicated.

The reporting forms enclosed should be considered as master copies to be used for future month's reporting. Providers may replicate the reporting forms however; replicated forms must be **exact** duplicates of the Department's forms (i.e., same format and content).

The reports must be completed and submitted in accordance with these instructions. If, upon review, a report is deemed unacceptable, the report may be returned and a delinquency notice issued. Failure to comply with the reporting provisions provided in PHL Sections 2807-j and 2807-s may result in recoupment of the facility's estimated monthly assessment liability, along with interest and/or penalty, from various third party payments pursuant to PHL Section 2807-j (6). Additionally, PHL Section 2807-j (7)(c) authorizes the Commissioner to assess civil penalties for certain reporting delinquencies.

Please note that the guidance offered in these instructions is not all-inclusive. Please refer to the New York Health Care Reform Act (1996 and 2000) and related correspondence previously disseminated by the Department which is available on the Department's WEB site.

Note that New York hospital based clinical laboratories issued a permit pursuant to Article 5 of the Public Health Law are not required to complete these forms since the revenue of such laboratories will be included on the outpatient report of their affiliated PHL Article 28 general hospital, which is physically located in New York State. Also, clinical laboratories issued such a permit which are part of a PHL Article 28 Comprehensive Primary Health Care Diagnostic and Treatment Center physically located in New York State (which is subject to the surcharge provisions) are not required to complete these forms since the revenue of such laboratories will be included in the report of such PHL Article 28 Comprehensive D&TC.

FREESTANDING CLINICAL LABORATORY CERTIFICATION FORM

- **MONTH/YEAR**: Enter the month and year for which data is being reported.
- **PROVIDER NAME**: Enter the name of the provider.
- **ADDRESS**: Enter the address of the provider.
- **FEDERAL TAX ID NUMBER**: Enter the federal identification number that is used by the provider for federal tax purposes.
- **PERMANENT FACILITY IDENTIFIER (PFI#)**: Enter the laboratory's permanent facility identifier. **THE LABORATORY'S PFI# MUST BE ENTERED ON THE REPORTING FORMS AND PAYMENT CHECK.**
- **COMPLETED BY/TITLE/TELEPHONE**: Enter the name, title and telephone number of the person who will be responsible for providing the Department related information regarding the provider's report form(s).
- **CONSOLIDATED REPORT:** Indicate whether the certification and reporting submission represent a consolidated reporting submission for a freestanding clinical laboratory that is a parent company with a number of subsidiaries by entering an "X" in the box. The Summary of Consolidated Report Submission form must be completed.
- **CERTIFICATION**: Enter the name of the person who is certifying to the accuracy and correctness of the report form(s) submitted.
- **SIGNATURE/DATE**: The person responsible for certifying the accuracy and correctness of the report form(s) submitted should sign and date the form. **SIGN IN BLUE INK ONLY**.
- **TYPE/PRINT NAME**: Print or type the name of the person responsible for certifying the accuracy and correctness of the report form(s) submitted.
- **TITLE**: Enter the title of the person responsible for signing the Certification form.

FREESTANDING CLINICAL LABORATORY CERTIFICATION FORM (Con't)

Summary of Consolidated Report Submission

- **MONTH/YEAR:** Enter the month and year for which data is being reported.
- **PROVIDER NAME:** Enter the parent company laboratory name.
- **PFI #:** Enter the laboratory's permanent facility identifier.
- **CONTACT/TELEPHONE #:** Enter the name and telephone number of the person who will be responsible for providing the Department related information regarding the provider's report form(s).
- List the name and PFI # of each entity being reported by the parent company.

PAYMENT SUMMARY

Self explanatory. This page also contains information on who to make the check payable to and where to mail the payment and reports. Faxed copies of the monthly reports are not acceptable.

REPORT OF PATIENT SERVICES REVENUE RECEIVED AND SURCHARGE OBLIGATIONS

IMPORTANT:

Pursuant to the New York Health Care Reform Act of 1996 (HCRA), each service year's pool receipts are dedicated to specific purposes and for specific amounts. **As a result, monthly reports filed by providers must be segregated into service year portions.** For example, providers must include revenue received for services provided in 1997 in the 1997 portion of the report even though the revenue was received in a subsequent service year. In addition, any prior period adjustments must be reported in the service year section of the report to which they apply. For example, a correction of an amount reported for service year 1997 must be reported as a prior period adjustment on the 1997 portion of the monthly report.

GENERAL INSTRUCTIONS
At the top of the form:

Enter an "X" in the box at the top of the report form if the provider has received no net patient services revenue during the report month for visits made or services rendered during the specified service year and has no adjustments to patient services revenues previously reported for the specified service year.

- **MONTH/YEAR**: Enter the appropriate report date.

- **PROVIDER NAME**: Enter the name of the provider.

- **PERMANENT FACILITY IDENTIFIER (PFI#)**: Enter the laboratory's permanent facility identifier. **THE LABORATORY'S PFI# MUST BE ENTERED ON THE REPORTING FORMS AND PAYMENT CHECK.**

ENTER WHOLE DOLLAR AMOUNTS ONLY

COLUMNAR DESCRIPTIONS

Column A - Description. This column itemizes total net patient services revenue received, including surcharges.

Column B - Current Month. This column is to be used for reporting total net patient services revenue received during the report month, including surcharges. If there are no prior period adjustments to report in Column C, do not complete this column. See Column D instructions.

Column C - Prior Period Adjustment. This column is to be used for reporting adjustments due to a reporting error or omission in a prior month. This may be either a positive or negative adjustment. Denote negative amounts with brackets (). Detailed records must be maintained since all report information is subject to audit.

Column D - Total. Add the individual amounts reported in Column B to the respective amounts reported in Column C and enter the result on the appropriate line in Column D. If there were no prior period adjustments in Column C, total net patient services revenue received during the month may be entered in Column D only.

NET PATIENT SERVICES REVENUE - definition/assessability, in general:

In general, net patient services revenue shall mean all moneys received for or on account of hospital or medical services provided or related to patients whose purpose is the treatment or prevention of human illness, disease, injury or disability. **Providers should refer to the Line 2 instructions for a more specific definition of net patient services revenue for freestanding clinical laboratories (PHL Section 2807-j).**

Examples of revenue which fall outside this definition include: revenue received for clinical laboratory tests performed in connection with the screening of employees for drug use; revenue received for clinical laboratory tests and/or physical examinations performed in connection with applications for life insurance, health insurance, disability insurance or employment; revenue received for clinical laboratory tests performed for the purpose of establishing paternity; and revenue received for forensic laboratory testing.

It should be noted that certain grants and other revenue would be included and may be considered assessable if representing moneys received for the provision of care or other health-related services to individuals. Note however, that government deficit financing grants are never assessable. Such deficit financing grants would be included in Line 2 and then shown as non-assessable on Line 4(f).

LINEAR DESCRIPTIONS

Line 1 - Total Laboratory Revenue Received. Enter total laboratory revenue, including patient services revenue and other operating revenue and non-operating revenue, received during the report month, for visits made or services rendered during the specified service year, on this line.
IMPORTANT NOTE FOR LABORATORIES LOCATED OUTSIDE NEW YORK STATE: Laboratories located outside New York State may enter total revenue received during the report month from New York State drawn specimens only on this line.

Line 2 - Total Net Patient Services Revenue Received, including surcharges. Enter total net patient services revenue, including surcharges, received during the report month, for visits made or services rendered during the specified service year, on this line. Be sure to include grant revenue on this line. This amount should also include recoveries received from accounts receivable previously written off as uncollectible. Net patient services revenue includes assessable and **non-assessable** patient services revenue. Net patient services revenue must be reported in the month it is received.
IMPORTANT NOTE FOR LABORATORIES LOCATED OUTSIDE NEW YORK STATE: Laboratories located outside New York State may enter net patient services revenue received during the report month, including surcharges, from New York State drawn specimens only on this line.

Pursuant to Section 2807-j (3)(c) of the PHL, net patient services revenue for freestanding clinical laboratories shall mean all moneys received, including capitation payments, less refunds, for or on account of visits made or services performed on or after January 1, 1997, or contracted service obligations for periods on or after January 1, 1997, for clinical laboratory services provided or related to human specimens. This section of the Public Health Law applies to all service years subsequent to 1997. **Note that exemption Line 4(h) is provided on the 2000 service year portion of the report for reporting revenue received for or on account of clinical laboratory visits made or services performed during the October 1, 2000 through December 31, 2001, service period.**

Line 3 - Revenue from Laboratory Specimens Drawn or Collected Outside New York State, for visits made or services rendered during the specified service year, would be reported on this line. The amount reported here would be net of revenue from laboratory specimens drawn or collected outside New York State relating to Medicare eligible beneficiaries or patients covered under the Federal Employees Health Benefits Act (FEHBA) and certain federal government payors such as Job Corps, CHAMPUS/Tricare and VA which are reported on Lines 4(a) and 4(b), respectively. IMPORTANT NOTE: Laboratories located outside New York State are not required to report revenue from laboratory specimens drawn or collected outside New York State on Line 2 above, therefore it would be unnecessary to make an entry on this line.

Line 4 - Other Non-Assessable Revenue. Report non-assessable net patient services revenue received during the report month, for visits made or services rendered during the specified service year, according to the following categories. **IMPORTANT NOTE: All these amounts must be included on Line 2 - Total Net Patient Services Revenue Received, including surcharges.**

a. Report payments related to Medicare eligible beneficiaries on this line. Payments (by Medicare and other payors) to designated providers of services for patient services provided to persons who are eligible for payments as beneficiaries of Title XVIII of the federal Social Security Act (Medicare) are not subject to the HCRA surcharges. This applies whether Medicare is the primary payor or the secondary payor. Also to be included are related co-payment, deductible and coinsurance revenue received. **However, revenue received from payors (including patients) making payments to a designated provider where Medicare benefits have exhausted for a particular service or for an uncovered service, shall be subject to all applicable surcharges.** The specific surcharge(s) to be applied will be dictated by whether the payor has voluntarily elected to pay the Department's pool administrator directly.

b. Payments related to patients covered under the Federal Employees Health Benefits Act (FEHBA) and certain federal government payors such as Job Corps, CHAMPUS/Tricare and VA would be entered on this line. Include related co-payment, deductible and coinsurance revenue received.

c. Report payments received for contracted services performed for other designated providers on this line. Example: A clinical laboratory owned and operated by a general hospital performs certain laboratory tests on New York State drawn specimens provided by a freestanding clinical laboratory. The HCRA surcharges do not apply to the amount the hospital clinical laboratory bills and receives in payment from the freestanding laboratory.

d. Revenue received for services provided to subscribers of an HMO operating in accordance with the provisions of Article 44 of the PHL or Article 43 of the Insurance Law, which owns and operates the laboratory, would be reported on this line. Note that this would include uncovered as well as covered services.

e. Report here, all grant revenue from the Health Care Initiatives Pool included in Line 2. Examples include grants for the following programs: Health Facility Restructuring, Commissioner's Priority Pool, Health Care Quality and Improvement, Aids Drug Assistance Program, Emergency Medical Services, Children's and Cancer Hospitals, and Health Workforce Retraining (PHL Section 2807-l).

f. Report government deficit financing grant revenue on this line.

g. Other - Include all other non-assessable patient services revenue received during the report month, **which is not reportable on Lines 4(a) through 4(f)**, on this line. Refer to Section 2807-j (3)(c)(i) through (iv) of the PHL for a list of non-assessable patient service revenue items. Examples include co-payments received from patients eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law (Medicaid), as well as Health Care Services Pool and Professional Education Pool distributions. Additionally, report here certain payments made directly by New York State and its local governmental subdivisions that are non-assessable. Refer to the instructions for Lines 7(a), 7(b) and 7(c) for assessable payments received directly from New York State and its local governmental subdivisions.

h. Revenue received for or on account of clinical laboratory visits made or services performed during the October 1, 2000 through December 31, 2000 service period, is reported on this line.

Line 5 - Total Other Non-assessable Revenue. Enter the sum of the individual amounts reported in the Line 4 subcategories.

Line 6 - Total Assessable Revenue. Line 2 minus (Line 3 plus Line 5).

Line 7 - Net Assessable Revenue Received from Direct Pay (Electing) Payors (The payors whose names appear on the NYS Department of Health WEB site elector list and the State's fee-for-service Medicaid Program). The HCRA WEB address is www.health.state.ny.us/nysdoh/hcra/hcrahome.htm. Net patient services revenue received during the report month from direct pay payors, for visits made or service rendered during the specified service year, must be segregated into the following categories:

a. Medicaid, including HMO/PHSP - Report payments received directly from the Medical Assistance Program as well as from electing Health Maintenance Organizations (HMOs) and Prepaid Health Services Plans (PHSPs), for services provided to patients eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law (Medicaid).

b. Other 5.98% Payors - Report payments received directly from electing agencies of the State of New York (e.g., Office of Mental Health payments for services provided to individuals residing in State operated developmental centers) which have as a program component direct reimbursement to hospitals for rendered inpatient services and payments received directly from electing local governments (in New York State) **ONLY** for services provided to correctional facility inmates.

c. All Other Direct Pay Payors (8.18% Payors). This would include payments from electing local governments (in New York State) for other than correction facility patients and payments by electing self-insured governmental entities in connection with health benefits for their employees (including Workers' Compensation and No-Fault).

Line 8 - Total Net Assessable Revenue Received from Direct Pay Payors. This line is the sum of Lines 7(a) through 7(c).

Line 9 - Total Assessable Revenue Received from Non-Direct Pay Payors, including surcharges. Line 6 minus Line 8. The amount reported in Column D, Line 9 must be segregated into the categories listed in Column A, Lines 10 through 14 of the corresponding service year report.

COLUMNAR DESCRIPTIONS - Lines 10 through 14

Column A - Non-Direct Pay Payors. Provides specific line descriptions of non-direct pay payors.

Column B - Total Assessable Revenue, including surcharges. This column is to be used to report total net patient services revenue received from non-direct pay payors during the report month (Column D, Line 9 of the corresponding service year report). However, where a provider erroneously reported non-direct payor payments under the wrong surcharge factor (Column B, Lines 10 through 14) on a prior month's report, then equivalent positive and negative adjustments should be netted from the affected line totals and adjusted amounts reported on the appropriate line in Column B.

Column C - Surcharge Factor. This column provides the appropriate surcharge factor for each class of non-direct pay payors shown in Column A, Lines 10 through 14.

Column D - Assessable Base. Column B divided by Column C.

Column E - Surcharge Payable. Column B minus Column D.

LINEAR DESCRIPTIONS - FOR ASSESSABLE REVENUE - COLUMN B.

Line 10 - Medicaid-HMO/PHSP/Non-Specified 5.98% Payors. Report payments received from non-electing HMOs or PHSPs and any payor not specifically listed in PHL Section 2807-j (1) (non-specified payors), for visits made or services provided during the specified service year to subscribers eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law. See Line 13 for non-specified payor example.

Line 11 - Other 5.98% Payors. Report payments received directly from non-electing agencies of the State of New York (i.e., Office of Mental Health payments for visits made or services provided during the specified service year to individuals residing in State operated developmental centers) which have as a program component direct reimbursement to hospitals for rendered inpatient services and payments received directly from non-electing local governments (in New York State) **ONLY** for visits made or services provided during the specified service year to correctional facility inmates.

Line 12 - Self-Pay Uninsured, and Patient/Secondary Payor Co-pay, Deductible and Coinsurance Amounts (where primary payor is a direct pay payor).

Self-Pay Uninsured - Report revenue received during the report month from patients who do not have any third party health insurance coverage in whole or in part, and also revenue from insured patients who have exhausted their health care benefits or are making payments for an uncovered service, except for certain HMO patients described on Line 4(d), for visits made or services rendered during the specified service year.

This line would also include patient and secondary payor co-payment, deductible and coinsurance amounts where the primary payor is a direct pay payor. **This amount would be net of the amount reported on Line 19 as co-payment or deductible patient payments for which the patient's third-party payor has voluntarily submitted related surcharges to the Department's Pool Administrator.**

Line 13 - Non-Specified 8.18% Payors. Enter total net patient services revenue received during the report month from any payor not specifically listed in PHL Section 2807-j (1), for visits made or services rendered during the specified service year. Example: A freestanding clinical laboratory has a contractual agreement with a nursing facility to perform certain laboratory services on New York State drawn laboratory specimens provided by the nursing facility. The freestanding clinical laboratory is providing a surchargeable service for the nursing facility (non-specified payor). The HCRA surcharges apply to the bill the freestanding clinical laboratory submits to the nursing facility. Since the nursing facility is not a specified payor pursuant to Public Health Law and is therefore not required to make an election to make pool payments directly, only the 8.18% surcharge applies.

Line 14 - All Other Non-Direct Payors. Report on this line payments received during the report month from payors subject to the 32.18% surcharge for visits made or services rendered during the specified service year. This would include any payor specified under Public Health Law as being allowed to remit pool payments directly which has not made such election. Note also that this would include patient and secondary payor co-payment, deductible and coinsurance amounts where the primary payor is a non-electing payor.

LINEAR DESCRIPTIONS - SUMMARY LINES.

Line 15 - Total Assessable Revenue, including surcharges. Sum Column B, Lines 10 through 14. This amount must equal the amount reported in Column D, Line 9 of the corresponding service year report.

Line 16 - Gross Surcharges Payable. Sum Column E, Lines 10 through 14.

Line 17 - Less: Administrative Fee. This line is the product of 2% of the amount reported in Column D, Line 14.

Line 18 - Net Surcharges Payable for the Month. Line 16 minus Line 17. This amount should be brought forward to the appropriate line on the Payment Summary.

Line 19 - Co-pay or Deductible Patient Payments. Enter total co-payment and deductible patient payments received during the report month, for visits made or services rendered during the specified service year, for which the patient's third-party payor had voluntarily submitted related surcharges to the Department's Pool Administrator. This amount should have been netted against the gross amount otherwise reportable in Column B, Line 12 and the net amount reported on such line.